Results: The procedure enabled restoration of oral diet and allowed restoration of run off for saliva.
Conclusions: This is the first reported transcervical, radiologically guided technique to treat neopharyngeal stenosis following surgical treatment for head and neck cancer. It demonstrates a novel and efficacious approach to managing total neopharyngeal stenosis refractory to endoscopic dilatation. This safe and simple procedure may be considered in the management of this rare but significant complication.

0470 TOTAL LAPAROSCOPIC MANAGEMENT OF COLONIC PERFORATION WITH SIGMOID 'PERFOROSTOMY'

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Aims: Minimal access surgery is under utilised in the management of colonic emergency. This study reports on the use of laparoscopy to manage colonic perforations. We describe an alternative approach to the conventional management of colonic perforations, solely using laparoscopic techniques.
Methods: Sequential patients with non-neoplastic colonic perforation and evidence of minimal faecal contamination at laparoscopy were analysed. Following diagnostic laparoscopy, peritoneal toilet was achieved by copious lavage. The sigmoid colon was mobilised and the perforation site was exteriorised to form a stoma – 'perforostomy'.
Results: Two patients, 43 year old male and 66 year old female, presenting with idiopathic sigmoid perforation and delayed iatrogenic recto-sigmoid perforation post-polypectomy respectively, were managed utilising this approach. In both cases, the perforostomy was completed without conversion to open surgery. Successful reversal of their perforostomies was performed in the fourth post-operative month.
Discussion: The modern management of colonic perforation is evolving. The above procedure can facilitate this process by providing an intermediate strategy between the traditional Hartmann's procedure or the more recent laparoscopic drain insertion for pelvic sepsis. The laparoscopic exteriorisation of the perforated site reported here represents a novel approach. It achieves faecal diversion without requiring the construction of a conventional stoma.

0472 ENHANCED RECOVERY IS FEASIBLE IN BARIATIC PATIENTS: EARLY OUTCOMES OF ENHANCED RECOVERY FOLLOWING LAPAROSCOPIC ROUX-EN-Y GASTRIC BYPASS

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Aim: We introduced an enhanced recovery protocol (ERP) for our bariatric patients in May 2009. We have evaluated our early outcomes following laparoscopic roux-en-y gastric bypass (LRYGB).
Methods: Our ERP includes: Ten day liver reducing diet; Catheters, nasogastric and postoperative surgical drains are not routinely used. Day 0 - early ambulation and sips, day 1 - free fluids, day 2 - soft diet. Home on the 2nd/3rd postoperative day. We compared early outcomes in historical (group A, n=121) versus enhanced recovery patients (group B, n=188).
Results: 309 patients underwent LRYGB between January 2005 and August 2010 with no mortality. Following the implementation of ERP we have reduced our operating time (3h21m v 2h46m, $p<0.0001$) and postoperative hospital stay (5.1 days v 2.7 days, $p<0.0001$) with no difference in early (<30d) readmission rates (9.1% v 4.8%, $p=0.1576$). In both cohorts, 3 patients have required surgery in the early (<30d) postoperative period. This data includes the learning curve of all three of our surgeons.
Conclusions: We report the safe adoption of an ERP for LRYGB. Operating time and hospital stay have significantly reduced without evidence of adverse outcomes, some of which may be attributed to learning curve experience.

0474 VASCULAR SURGERY CASE REPORT: TRELLIS-8 PHARMACO-MECHANICAL THROMBECTOMY SYSTEM FOR THE TREATMENT OF ILIOFEMORAL DEEP VENOUS THROMBOSIS

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Aims: To present and discuss the first patient in our hospital to undergo treatment with Trellis-8 Pharmaco-Mechanical Thrombectomy (PMT) system for Iliofemoral deep venous thrombosis (DVT). Methods/Case: A 46 year old male presented with an acute painful swelling of the left thigh. Ultrasound (US) Doppler identified left common femoral/external iliac DVT. US guided percutaneous puncture of the left popliteal vein was performed. The Trellis-8 catheter was advanced through the clot. Tissue Plasminogen Activator was delivered between two occlusion balloons positioned at opposite ends of the clot, while a powered oscillating wire caused clot breakdown and facilitated with clot aspiration via the catheter. Post-procedure venography demonstrated a patent venous system and clinically there was reduced leg swelling. The procedure was well tolerated with no complications and the patient had an overnight stay in surgical special care.
Results/Discussion: Isolated Thrombolysis with Trellis-8 is characterised by reduced lytic dosage, shorter treatment times, reduced systemic effects of thrombolytics, maintenance of valvular function, lower costs and fewer long-term complications compared to conventional forms of DVT treatment.
Conclusion: Trellis-8 enabled thrombus removal in a single visit to the interventional angiography suite. Continued surveillance and audit of a cohort of patients will determine long-term success rates.

0475 EVALUATION OF SURGICAL TEAM PERFORMANCE IN ELECTIVE OPERATIVE THEATRES

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Introduction: Theatre teamwork performance correlates well with technical error rates. Measurement of both concepts requires carefully developed and validated methods. We studied teamwork and process variations in elective orthopaedic surgery using new methods, and present our initial results and data on the reliability of the new scales.
Methods: Researchers (Human Factors Specialists and Surgical Trainees) were trained in observational methods for evaluating teamwork (Oxford NOTECHS II) and the identification of surgical flow disruptions (Glitch count) which were co-operatively developed by research group members from earlier versions. After initial training, observers validated their scale use by pairwise independent observation of hip and knee replacement operations, comparing scores retrospectively. Agreement was evaluated using the RWG (J) test.
Results: 20 elective orthopaedic operations were observed. Excellent agreement was demonstrated between all observers. Less agreement is found with scoring the nursing sub-teams, and the highest when scoring surgical sub-teams. A linear Regression analysis demonstrates a relationship between operative duration and the number of glitches ($r2=0.41$, 6.33 glitches/min $\pm$ 2.88 SE, $p=0.044$), but not non-technical skills.
Conclusion: Oxford NOTECHS II and Glitch count proved reliable in this group of observers. Teamwork and technical performance of the teams was high, but scope for improvement was identified.

0480 SURGICAL POSTGRADUATE PORTFOLIOS – ARE THEY CUTTING IT WITH TRAINEES?

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Aim: Postgraduate training has widely adopted the portfolio to measure progression. Surgery is a craft specialty and therefore, we hypothesized that expectations and utilisation of portfolios would differ between specialty trainees.
Methods: A piloted, mixed methodology questionnaire was distributed via multiple routes to postgraduate trainees in surgery, medicine and general practice.

Results: 147 completed questionnaires were received. A majority of GPs (59%) but fewer medical (16%) and surgical (27%) trainees reported a favourable portfolio experience. Surgical trainees reported low levels of support and feedback within portfolios but 36% acknowledged its relative usefulness in charting clinical skills. No group considered portfolios to provide an accurate reflection of trainees' knowledge and clinical judgement, although positivity regarding portfolios increased with years of utlisation.
Conclusions: The fact that the portfolio can be used as a log book to chart clinical skills is pertinent in a craft specialty and since surgeons have been using log books in paper form for decades, this may explain their relative acceptance of this aspect of the portfolio. Portfolios require further development as an educational assessment tool. The higher acceptance of portfolios by GP trainees may relate to their use within a closely mentored training environment.

0482 **OPEN OR LAPAROSCOPIC APPENDICECTOMY IN A DGH SETTING**
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Aim: The value of laparoscopic appendicectomy (LA) over open appendicectomy (OA) is contentious. The aim of this study was to audit the outcomes of the two techniques over a 6 months period in a DGH setting.
Methods: Patients undergoing emergency appendicectomies over a 6 month period in a single institution were audited. Outcomes recorded included demographics, grade of operating surgeon, duration of surgery, complications and postoperative length of stay (PLOS).
Results: Ninety four patients (M:F, 49:45; median age 24 (15-43) years) were recruited. The majority of cases were performed laparoscopically (45 (48%) LA , 32 (34%) OA , and 17 (18%) conversions) . Twelve (13%) procedures where performed by consultants, or with a consultant present, of which only 3 (3%) were performed laparoscopically. Median operative time was longer for LA (LA 90 (74-121) min versus OA 65 (49-130) minutes; p=0.002). Eleven (12%) patients developed complications. There were no differences in PLOS between LA and OA (respectively 1(1-3) and 2 (1-2) days; p=0.893).
Conclusion: Longer operative times and high conversion rates question the value of laparoscopic appendicicectomy in a DGH where formal training for this procedure is not always readily available.

0484 **IMPROVED CENTRAL LINE MANAGEMENT, FACILITATED BY AUDIT, POTENTIALLY REDUCES LINE SEPSIS**
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Aim: Prolonged use of a Central Venous Line (CVL) carries increased infection risk. However, rigorous monitoring of the length of time lines are in situ and documenting the reasons for continued use are not frequently performed. This audit describes a simple intervention and the subsequent improvement in clinical practice.
Method: Two 3-week audit cycles were completed, surveying all patients having CVL placement within a two week period, allowing one week for follow-up. Demographic data, CVL indication, duration and complications were collated. Following one cycle, proformas were placed routinely on patients' observations charts, prompting daily review of CVL indication and complications by medical staff. The cycle was then repeated.
Results: Between cycles 1 and 2, 17 and 19 lines were placed: groups were similar in baseline demographics, operative contamination, emergency/elective status, and CVL indications. Regular re-appraisal of CVL indication/complications increased in both nursing p=0.037, and medical notes p<0.001 between cycles. Line sepsis reduced after the intervention (n=3 cycle 1, n=0 cycle 2) p=0.095. Median duration of each CVL was 4.5 and 4.0 days respectively.
Conclusion: This intervention has increased awareness of staff, significantly improving documentation, with a concordant reduction in line related sepsis over the study period.

0485 **LAPAROSCOPIC COLORECTAL SURGERY – INITIAL EXPERIENCE IN A SMALL UK DISTRICT GENERAL HOSPITAL**
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Aim: To assess the safety and efficacy of laparoscopic-assisted colorectal surgery in a small District General Hospital (DGH).
Methods: A retrospective case note review of all patients undergoing laparoscopic colorectal resection (benign and malignant conditions), between Dec 07- Feb 2010, in a single unit, was performed.
Results: All procedures were performed by one operator (DM), at the initial part of the learning curve. Forty patients, age range 42-92 yrs, underwent colorectal resection. Operations included, 11 right hemicolectomies, 21 left sided/anterior resections, 2 APR, 2 panproctocolectomies and 4 rectopexys. Malignancy resection was performed on 26 patients. Conversion to open surgery was 37.5%, 12.5% being due to adhesions. Mean length of procedure- 3.5 hours. There was 1 anastomotic leak, ultimately dying, mortality rate 2.5%. Median hospital stay was 9 days.1 patient had a positive CRM. Median lymph node harvest-12.
Conclusion: There is a paucity of reports in the UK assessing the safety and efficacy of laparoscopic colorectal surgery in DGHs. Our study, from a small DGH, shows laparoscopic colorectal surgery to be safe, with acceptable outcomes in terms of morbidity, mortality and oncologically. This study, (detailing initial outcomes) is in keeping with the results from the UK CLASICC trial.

0486 **FIFTY-ONE INGUINAL HERNIAE REPAIRED UNDER LOCAL ANAESTHETIC WITH EXCELLENT SATISFACTION RATINGS AND LOW PAIN SCORES**
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Aim: To determine acceptability and feasibility of delivering a day surgery local anaesthetic hernia repair (LAHR) service.
Methods: Prospective data was collected following patient counselling, preoperative priming in an outpatient setting, and LAHR in day surgery using a LA 'cocktail' solution allowing a maximum of 106mls per person. Age, sex, BMI, surgeon (consultant or trainee), length of procedure, volume of LA required, Visual Analogue Scores (VAS) of patient satisfaction and pain experience using 10cm line scored out of 100, and finally patient choice were recorded.
Results: Of 51 patients mean age was 64.5years (32-92), M:F ratio 46:5, mean BMI 24.7(19-32), duration of procedure 54.6mins(23-100), and mean volume of LA solution used was 42.9ml(14-84). Patient satisfaction scored mean95/100, median96/100 (range 71-100/100). Pain score mean 20/100 and median 16/100 (2-60/100). At the end of LAHR, patients were asked their choice for hernia repair, 45(88.2%) chose LA while 6(11.8%) opted for GA. Comparison of trainee (n=32) versus consultants (n=19) revealed higher pain scores of 26.3 in the consultant group vs 16.2/100. The 6patients who chose GA as preference had pain scores of 44.0 vs 16.7/100 of the LA group.
Conclusions: LAHR has been successful with high satisfaction ratings and low pain scores.

0487 **COLONOSCOPY ASSISTED LAPAROSCOPIC RESECTION OF CAECAL POLYPS**
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Background: Colonic polyps are a frequently occurring pathology and as there is abundant evidence that virtually all colorectal carcinomas begin as adenomatous polyps, early resection is recommended prior to progression to carcinoma. There has been debate about the endoscopic versus surgical management of those adenomatous polyps which are larger than 15 mm in diameter, are flat and extended or difficult to see as endoscopic resection carries with it a risk of perforation. Traditional surgical management may